

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 12/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 1 B. WING _____	(X3) DATE SURVEY COMPLETED 11/24/2015
NAME OF PROVIDER OR SUPPLIER ARLEIGH BURKE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 1739 KIRBY ROAD MC LEAN, VA 22101		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 29282 Description of structure: The facility is a two story with a construction type of II(111). Sprinkler status: The facility is a fully sprinklered building. An unannounced recertification Life Safety Code survey was conducted 11/24/2015 in accordance with 42 Code of Federal Regulation, Part 483.70: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the 2000 Life Safety Code. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000	The procedure for auditing the facility's environment has been evaluated. Environmental rounding will also include a review of facility exit doors and corridors to ensure accessibility. All personnel responsible for monitoring the environment as it relates to exit doors and corridors have been re-inserviced. Weekly monitoring of the environment will continue by the Maintenance Supervisor. Any infractions noted will be reported to the QA committee for further monitoring and evaluation.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3	K 025		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 This Standard is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain resistance rating of an assembly. This has the possibility to affect 25% of the residents. The Findings Include: On 11/24/2015 at approximately 10:39 am, it was identified by observation there was an unsealed penetration above the fire doors to the Admin hall.	K 025		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This Standard is not met as evidenced by: Surveyor: 29282 Based on observations it was determined the health care facility failed to maintain an exit. This has the possibility to affect 10% of the residents. The Findings Include: On 11/24/2015 at approximately 10:39 am, it was revealed by observation there were mobile wardrobes partially blocking the exit corridor in Admin.(Corrected on site)	K 072		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495410	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - COMMUNITY BLDG B. WING _____	(X3) DATE SURVEY COMPLETED 11/24/2015
NAME OF PROVIDER OR SUPPLIER ARLEIGH BURKE PAVILION		STREET ADDRESS, CITY, STATE, ZIP CODE 1739 KIRBY ROAD MC LEAN, VA 22101		
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K 000	INITIAL COMMENTS Surveyor: 29282 Description of structure: The facility occupies two floors of a three story with a basement building with a construction type of I (322). Sprinkler status: The facility is a fully sprinklered building. An unannounced recertification Life Safety Code survey was conducted on 11/24/2015 in accordance with 42 Code of Federal Regulation, Part 483.70: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the 2000 Life Safety Code. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)	K 000	K025 The flange for smoke damper by room 136 was corrected on site. The fire flange for the damper in the electrical room was corrected. The pipe penetrations on G15 wall by stair A and penetration above the fire doors to the Admin hall were sealed. A facility wide audit of all smoke and fire dampers was performed with no additional infractions noted. A facility wide audit to ensure smoke barriers and/or fire proofing are in place has been completed by an outside contractor.	01/08/16
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3	K 025	Scheduled monitoring and/or maintenance to the fire dampers will be completed as recommended by the manufacturer. Inspection of fireproofing will be added to the "Environmental Tools" checklist." The personnel responsible for monitoring of the environment as it relates to fireproofing and fire dampers have been in-serviced.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kathleen Brant Administrator 12/11/15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 This Standard is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to maintain the resistance rating of assembly's. This has the possibility to affect 50% of the residents. The Findings Include: On 11/24/2015 at approximately 09:22 am, it was identified by observation the flange for the smoke damper by room 136 was not flush against the wall.(Corrected on site) On 11/24/2015 at approximately 09:33 am, it was identified by observation the fire damper flange in the electrical room is not installed properly. On 11/24/2015 at approximately 10:00 am, it was identified by observation there improperly sealed pipe penetrations G15 wall by stair A.	K 025	Any infractions noted through the scheduled monitoring will be reported to the QA committee. K027 The fire door to stair B on the first floor has been repaired. A facility wide audit of all door openings has been completed with no additional infractions noted. The procedure for monitoring the facility's environment related to door openings has been reviewed and amended. The Quality Assurance tool "Environmental Rounds" has been amended to include the inspection of all door openings to ensure smoke barriers are maintained. The personnel responsible for monitoring of the environment as it related to door openings have been in-serviced. Weekly monitoring of the facility environment will continue by the Maintenance Supervisor. Any additional infractions noted will be reported to the QA committee for further evaluation.		01/08/16
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	K 027			

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FORM CMS-2567(02-99) Previous Versions Obsolete

WILK21

If continuation sheet Page 3 of 5

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K 062	Continued From page 3 revealed by observation there was paint on several sprinkler heads in the hard ceiling by G06. On 11/24/2015 at approximately 10:06 am, it was revealed by observation there was paint on several sprinkler heads in the elevator 2 lobby. On 11/24/2015 at approximately 10:07 am, it was revealed by observation there was paint on several sprinkler heads in the connector.	K 062	K147 The unsupported power strip in the nurse office and reading lounge were both corrected on site. The items prohibiting adequate clearance around the panel box in the electrical room was corrected on site and the open electrical box in the elevator room was closed on site. A facility aide audit of all electrical wiring and equipment to include extension cords, adaptors, all electrical and elevator rooms has been completed with no further infractions noted. The procedure for auditing facility electrical wiring and equipment has been evaluated and amended. Communication has been provided to personnel related to extension cords, power strips and adaptors. Approval by the maintenance department of all extension cords and equipment must be received prior to installation.	01/08/16
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This Standard is not met as evidenced by: Surveyor: 29282 Based on observation the facility failed to prevent electrical hazards. This has the possibility to affect 45% of the residents. The Findings Include: On 11/24/2015 at approximately 9:17 am, it was identified by observation there was an unsupported power strip in the nurse office. (Corrected on site) On 11/24/2015 at approximately 9:30 am, it was identified by observation there was inadequate clearance around a panel box in the electrical room. (Corrected on site) On 11/24/2015 at approximately 9:35 am, it was identified by observation there was an unsupported power strip in the reading lounge. (Corrected on site)	K 147		

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K 147	Continued From page 4 On 11/24/2015 at approximately 9:53 am, it was identified by observation there was an open electrical box in the elevator room.	K 147	All personnel responsible for monitoring the environment as it relates to electrical wiring and equipment have been in-serviced. Weekly monitoring of the environment will continue by the Maintenance Supervisor. Any infractions noted will be reported to the QA committee for further monitoring and evaluation. K072 The mobile wardrobes partially blocking the exit corridor in the Admin suite were removed on site. A facility wide audit of all exit doors and corridors has been completed to ensure they are readily accessible at all times with no further infractions noted.	01/08/16